derful for appendicitis to be so uncommon in asylums and yet for intestinal kinks to be so common, obstruction being one of the causes of appendicitis. He did not know whether one should not consider that appendicitis had killed off those patients who were going to die of it before they became insane. Perhaps the old people who did not get appendicitis were protected from it by the chronicity of the kinks; and when they came to asylums and had laxative medicines administered to them, they were not liable to develop appendicitis. His statistics referred to an institution with a population of about 1050 patients and 150 staff. He remembered the surgeon operating upon two cases on the same morning. Both of them had pus-formation. In the North Stafford Infirmary he understood that the statistics of appendicitis were falling gradually, so one might conclude that it was now on the decline.

Dr. J. F. BRISCOE, in reply, said he was extremely obliged to the various gentlemen who had discussed his short paper, and he was indebted to the Commissioners in Lunacy for their help in the matter, for he had addressed the secretary, who kindly sent him the figures. Those figures set him thinking, and he began to read the subject up. He believed he had read every book on the subject, and from them he collected a large number of statistics. His original address would have been such a long affair that it would have been very tedious to listen to, and accordingly it was necessary to crystallise it. He might have added to it many points, some of those which had been raised in the discussion. He was obliged for the President's remarks. It was satisfactory to find that Dr. Soutar's experience coincided with his own as to the rarity of appendicitis among the insane. The remarks of his old teacher, Sir George Savage, interested him very much. With regard to the age-period, it was known that youths were more liable to appendicitis than were persons of greater age, and he reminded Mr. Buckell, who raised the point, that at Earlswood Asylum all the inmates were young. Dr. Percy Smith's remarks as to influenza, and Dr. Blair's concerning rheumatism, were very interesting. Dr. Fletcher Beach, who was formerly at Darenth Asylum, agreed that appendicitis was very rare there. Dr. Douglas Turner informed him that he found the disease rare also among his feeble-minded young people in the institution for idiots of which he was superintendent. A certain London surgeon had declared that it was possible to get rid of tuberculosis and rheumatism from the system by short-circuiting the intestine. He agreed that there should be no abuse of aperients. He agreed as to the function of Peyer's patches. There were those who likened the function of the appendix to that of an oil-can or lubricant. Some surgeons believed that in 25 *per cent.* of people the appendix was obliterated. The exciting cause of the condition in many cases was the entry into the appendix of foreign matter, which caused strangulation. The point raised by Dr. Menzies that intestinal kinks were common in the aged insane was of much interest.

Clinical Notes and Cases.

A Case of Acromegaly with Mental Symptoms. By GUY ROWLAND EAST, M.D., D.P.H., Assistant Medical Officer, Northumberland County Asylum.

A. B—, æt. 43, was admitted to Northumberland County Asylum suffering from delusional insanity. His bodily condition was one of well-marked acromegaly. Occupation—coal miner.

Family history.—None of his near relatives have been affected by acromegaly, or any similar or allied disorder such as myxœdema, exophthalmic goitre, brain tumour or diabetes. His relatives have all been tall and well developed. His family has not been subject to any hereditary disease.

His grandmother, a tall, strong woman, died, aged eighty-six, from a

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stroke. Cause of grandfather's death unknown. His father was 5 ft. 10½ in., weighed 14⅓ st., died, aged fifty-eight, from a stroke. His mother was very stout, height 5 ft. 10 in., weight 20 st., was rheumatic and died from fatty heart. She had six children—the patient being the second. There were three males and three females. Two males died at four months and one and a half years. One female at four and a half years. The other two females are still living and in good health.

Personal history and ætiology.—Patient had enjoyed excellent health until present disease began. Has only twice been confined to bed. When thirty had an attack of pleurisy and at forty was treated for lumbago. Both these diseases being common amongst miners working in wet pits. He had never contracted syphilis. When nineteen he was 5 ft. 7½ in. and weighed 10 st. When twenty-one he was 6 ft. ½ in. and weighed 12 st. 6 lb. From this age he noticed that his head, hands and feet gradually became enlarged. He noticed the enlargement first in the head, next in the hands and finally the feet. He says his sight has always been good and he never wore glasses for reading. For the last year or two he has perspired excessively on exertion and has been subject to occasional shooting pains in the limbs and back of head. At times he had severe headaches.

Present condition and symptomatology.—Patient's height is 6 ft. ⅓ in. and weighs 17⅓ st. His body, as a whole, looks broad and thick. The head and face appear big in proportion to the rest of his body. The hands are greatly enlarged, the feet less so. When he stands erect the head is slightly inclined forwards, while the back and shoulders are rounded, the chest and abdomen somewhat prominent. The double hump (of Marie), which is characteristic of the disease, is beginning to be developed. Patient is dark complexioned and well nourished. A muscular man, but says he soon tires on exertion. Gait heavy, the feet are brought down with a thump in a clumsy manner, but there is no inco-ordination. Temperature usually subnormal.

Symptoms.—The chief complaint is a feeling of lassitude and disinclination for exertion. Is easily fatigued. Is subject to severe headache together with pains in limbs. Has never noticed any giddiness or inclination to vomit. Slight tinnitus occasionally of left ear. His sight is good; he can see equally well with both eyes and can read small print easily. There is no hemianopsia present.

His appetite has always been excessive and he has for many years suffered from great thirst, requiring as much as two pints of fluid at meals. His hands and fingers often become cold and dead and get yellowish in colour. He does not bear either heat or cold well.

Detailed description.—The appearance of the patient is highly characteristic, the face, hands and feet being all enlarged. The expression is somewhat heavy and apathetic. The colour of face pale and slightly grey, the skin of forehead and right temple showing brownish pigmentation. The conjunctival and buccal mucous membranes are anæmic. The condition of the blood was: red blood-corpuscles number 4,400,000 per cmm. and hæmoglobin 76 *per cent.* White corpuscles are diminished in numbers. On microscopical examination the red corpuscles were of normal shape, but paler than natural; they formed rouleaux; a few were tailed and irregular in shape.

The shape of face is distinctly more oval and elongated than normal —the lower half being large in proportion to the upper. The forehead is broad and high. The superciliary eminences are large and the temporal ridges strongly marked. Eyebrows thick and bushy. The orbital fissures look narrow in proportion to size of face, but are normal in width. The eyes are slightly prominent and set widely apart and when patient looks into distance the right eyeball is inclined outwards. The nose is much larger than before the disease began. Nostrils broad and thick, nasal septum thickened, the cartilages, bones and soft parts being obviously increased in size. The malar bones and zygomatic processes are markedly prominent. The aperture of mouth is broad in proportion to size of face. The upper lip is thick, but space between nose and red surface of lip is not longer than normal. The lower lip is thick, full and everted. The upper jaw is enlarged; the alveolar processes thickened; palate high and broad, space at roof of mouth too capacious. The lower jaw is much enlarged; it projects forwards at the chin and is widened laterally. It is increased in length and thickness. It is curved forwards and downwards from the alveolar processes, leaving a greater concavity upwards than normal. The angle of the lower jaw is less acute than normal. The teeth of the upper jaw are mostly carious; the lower incisors are small and widely separated—a condition which has developed since the disease began.

The tongue is broad and flat, deeply ridged on upper surface; it is somewhat hypertrophied. The tonsils, uvula, soft palate and pharynx appear normal.

The scalp is covered with thick, black hair turning grey, which is wiry and strong. Skull not enlarged except that the occipital bone beneath the protuberance is more marked than usual. The sutures between the temporal and parietal bones are unduly prominent. A distinct ridge can be felt corresponding to the line of the suture. The scalp is not scaly; neck is short and thick. Head usually projects somewhat forwards and downwards, the chin being nearer the sternum than usual. The voice is low-toned and harsh. He cannot sing high notes since the disease began. The larynx is slightly enlarged, the *Pomum Adami* somewhat prominent. The thyroid gland is enlarged, the left side more so than the right. There is a resonant note all over the upper part of the sternum on percussion. No evidence of the presence of the thymus gland (which in some cases of acromegaly is enlarged and persistent).

Upper extremities.—The hands are enlarged in all dimensions, especially in breadth; they are distinctly spade-shaped; the fingers are uniformly enlarged and flattened antero-posteriorly; the ends are not clubbed; the nails look small in proportion to the size of the hands, and are short, broad and flat; the bones of the hand, fingers and wrist are all enlarged. The palm is deeply ridged and furrowed. Large pads of fat are present over metacarpo-phalangeal joints, and thenar and hypothenar eminences. The wrists are thick and enlarged, the peripheral ends of radius and ulna being markedly thickened. The forearms look large, and so do the upper arms; the elbow and shoulder joints are normal; the clavicles are large. The spines of both scapulæ are unduly prominent; the first part of the sternum is much increased

in length and breadth. The vertebral spines are slightly enlarged; the cartilages of the ribs, especially second and third ribs, are prominent and enlarged, some of the ribs are thickened. The thorax is broad and deep; the circumference of the chest at nipple level is 41½ in.

The abdomen is somewhat increased in size, and at level of umbilicus measures 37¾ in.

The pelvis is large and broad; the iliac bones appear much thickened; the circumference at the iliac spines is 39½ in.

Lower extremities.—The feet, like the hands, are much enlarged, especially in breadth. They are flat; the toes are much increased in size, due to enlargement of soft parts; the big toes are large, flat and square at the ends; the ends of the metatarsal bones of the big toes are much increased in size. There are well marked corns on both second toes; the nails of the big toes are flattened and almost square. The soles are deeply furrowed and large pads of fat are present beneath metatarso-phalangeal joints; the peripheral ends of both tibiæ and fibulæ are enlarged. The legs have increased in size since the disease began, but the increase is small in proportion to that of the feet. The calf-muscles are prominent; plantar reflex vigorous; no ankle-clonus. The knee-jerks are normal; the knees have increased in size since the disease began. The thigh muscles are well developed.

The skin is unnaturally moist; he perspires very freely; the sensibility is normal. Taste, hearing, smell and sight are normal.

Mental state.—For a month previous to his admission to this asylum, he had been excited and refused to work. He had been wild in manner, incoherent in conversation, and quite incapable of taking care of himself. He had talked constantly on religious matters and had threatened his doctor with violence. He went out into the street and preached a sermon to the air. On admission he was wildly excited, quoting the scriptures volubly. He stated that the Holy Spirit was in him; that he had been chosen by God as His mouthpiece; that he had messages from Heaven to preach the gospel to all men; that the Holy Spirit had commanded him to convert the heathen. He was wildly maniacal for about three weeks and had on occasions to be confined to a padded room. He slept little and shouted himself hoarse, maintaining that by God's command he must preach the scriptures. He held long conversations with imaginary persons on religious matters. At the end of three weeks he became much quieter and steadily improved. He was allowed out of bed and became a useful ward worker. At this time his letters home bristled with biblical quotations, but he did not speak of these matters in conversation. In another fortnight the religious delusions disappeared altogether and he recognised the falsity of his former beliefs.

Three months after admission he was discharged recovered.

The condition of the urine.—He passed an increased amount of urine and had noted this for some years. The amount averaged 66 oz. daily. The urine was pale and generally contained mucus. Reaction strongly acid; specific gravity, 1018. There was no albumen or sugar, and peptones were absent. The amount of urea varied from 1·2 to 2 *per cent.* At times the urine contained a deposit of pink coloured urates.

The condition of the heart and pulse.—The heart appeared of normal

size. There was no valvular disease; the heart's action was rather feeble and accelerated. The pulse on admission was rapid and jerky, the rate being 96, but as he recovered mentally it gradually fell to 76.

The respiratory system was normal; in the early stages of his maniacal attack his respirations were slightly quickened, due to his excitement.

The alimentary system was normal. He had an exceptionally large appetite, but digested his food well. The bowels acted regularly.

Detailed measurements of the different parts of the body:

Height, 6 ft. $\frac{1}{8}$ in.; weight, 17 st. 6 lb.

Head and face.—Circumference of head, 24$\frac{3}{8}$ in.; length of head from glabella to occipital protuberance, 8$\frac{3}{8}$ in.; length from occipital protuberance to top of chin, 9$\frac{3}{8}$ in.; breadth of head across mastoid processes, 6$\frac{5}{8}$ in.; length from top of forehead to top of chin, 8$\frac{3}{8}$ in.; length from top of forehead to upper part of nasal bones, 3 in.; greatest width of alæ nasi, 1$\frac{5}{8}$ in.; length of nose from upper lip to tip, 1$\frac{1}{4}$ in.; length from septum of nose to top of chin, 3$\frac{1}{2}$ in.; greatest distance between outer surfaces of malar bones, 5$\frac{1}{8}$ in.; width of mouth, 3 in.; vertical measurement of lower lip, $\frac{5}{8}$ in.; breadth of tongue at its middle, 1$\frac{7}{8}$ in.; length of tongue on protusion from lower incisors to tip, 1$\frac{1}{2}$ in.; lower jaw—vertical measurement from gums to lower part of symphysis, 2 in.; length from temporo-maxillary articulation to tip of symphysis of lower jaw, 6$\frac{5}{8}$ in.; distance between the two angles of lower jaw, 5$\frac{1}{4}$ in.; ears, greatest length, 2$\frac{7}{8}$ in.; ears, greatest breadth, 1$\frac{5}{8}$ in.

Upper extremity.—Length of arm from acromion to olecranon, 16 in.; circumference of arm at its middle, 12$\frac{3}{4}$ in.; length of forearm from olecranon to styloid process of ulna, 13$\frac{1}{2}$ in.; circumference of forearm at its middle, 12 in.; circumference of wrist, 8$\frac{1}{2}$ in.; length of hand from wrist to top of middle finger, 9$\frac{1}{8}$ in.; length of middle finger from palmar fold, 4 in.; length of middle finger on dorsum from metacarpo-phalangeal joint to tip, 5$\frac{1}{8}$ in.; length of little finger on palmar aspect, 2$\frac{3}{4}$ in.; length of thumb on dorsum from metacarpo-phalangeal joint to tip, 3$\frac{1}{8}$ in.; circumference of middle finger, 3$\frac{1}{4}$ in.; circumference of little finger, 2$\frac{5}{8}$ in.; circumference of thumb, 3$\frac{1}{8}$ in.; antero-posterior diameter of middle finger, 1$\frac{1}{8}$ in.; length of nail of middle finger, $\frac{7}{8}$ in.; breadth of nail of middle finger, $\frac{3}{4}$ in.; length of nail of thumb, $\frac{7}{8}$ in.; breadth of nail of thumb, $\frac{1}{2}$ in.; circumference of hand (without thumb), 10$\frac{3}{4}$ in.; circumference of hand (with thumb), 12$\frac{1}{4}$ in.

Lower extremity.—Length of thigh from iliac crest to head of fibula, 21$\frac{1}{2}$ in.; circumference of thigh at middle, 20$\frac{1}{2}$ in.; circumference of knee over patella, 15$\frac{7}{8}$ in.; vertical diameter of patella, 3 in.; transverse diameter of patella, 3$\frac{5}{8}$ in.; length of leg from head of fibula to top of external malleolus, 16 in.; greatest circumference of calf, 14 in.; circumference of ankle, 11$\frac{3}{4}$ in.; greatest length of foot, 12 in.; circumference over heel and instep, 15$\frac{1}{2}$ in.; circumference of foot over back of toes, 10$\frac{1}{2}$ in.; greatest width of foot, 4$\frac{1}{2}$ in.; circumference of great toe, 5$\frac{1}{2}$ in.; circumference of middle toe, 2$\frac{3}{4}$ in.; circumference of little toe, 2$\frac{5}{8}$ in.; length of nail of big toe, $\frac{7}{8}$ in.; breadth of nail of big toe, 1 in.; length of great toe, 2$\frac{1}{8}$ in.; length of second toe, 1$\frac{1}{2}$ in.

Thorax and abdomen.—Circumference of neck, 17 in.; circumference of chest, 41$\frac{1}{2}$ in.; circumference of abdomen, 37$\frac{3}{4}$ in.; circumference of pelvis, 39$\frac{1}{2}$ in.

Congenital Hepatic Syphilis causing Recurrent and Fatal Hæmatemesis without previous Symptoms.

By D. McKINLAY REID, M.B., Assistant Medical Officer, Horton Asylum, Epsom.

T. B—, æt. 28, was admitted into Horton Asylum on April 17th, 1902, and was certified as a case of systematised delusional insanity. She showed well-marked signs of congenital syphilis—prominent, "bossed"